MENTAL HEALTH: SOME OF THE MAJOR ISSUES THAT NEED TO BE RESPONDED TO BY GOVERNMENTS.

"A serious problem will not be solved by further consideration of that problem within the mindset that has created it." ***Albert Einstein.***

This paper sets out to identify some of the major issues facing our mental health systems in Australia. In every State and Territory these same issues exist to varying degrees. Each of these issues needs to be responded to in the near term if the steady decline in our public mental health services is to be reversed and the high standards of care that are offered within privately-provided mental health services are to be maintained.

There first needs to be a **new statement** made by the different levels of government about each one's respective roles and responsibilities. Each of these should be a genuine and binding statement rather than a re-statement, since the process of this Inquiry might lead to conclusions and recommendations that could result in the current arrangements being altered radically.

Second, there needs to be an acceptance by governments that current problems in the various mental health systems will only be resolved by governments acting simultaneously on several fronts. Some of these will represent coordinated policy and legislative changes; some will require new approaches to community education about mental illness, at a broad level and also through the targeting of particular sections within communities. Next, governments will have to realize and accept the fact that for a time, our mental health systems are going to require additional financial resources. Finally governments will have to be prepared recognize and accept the consequences for Australia and its citizens of their failing to act and within a reasonable time frame.

This submission has been prepared following several years of personal experience (as a person with chronic mental illness) and direct observations of the mental health system(s) in Australia. Some attempt has been made to link the various observations and ideas in this document with specific terms of reference of the Inquiry.

FEATURES AND TRENDS.

In any overview of the mental health system, there are features and trends that come sharply into focus. In the main, and under current government arrangements, it is State governments and private providers who share responsibility for the provision of services to the mentally ill. Contrary to popular view, I consider that the greatest proportion of mental health services are being provided within the private sector, taking into account the numbers of patients who are being treated in a general practice setting as well as those people accessing private psychiatrists and private clinics. At the same time, in each state and territory there exists and extensive network of facilities and services which attract a steady level of criticism from consumers, carers and the media. Why is it that the public mental health sector considered to be so deficient?

TERMS OF REFERENCE A & B.

Priorities, Plunder and the new forms of Institutionalization.

In order to gain some appreciation as to how the present situation has been arrived at, I believe that the reader needs to first consider the more recent history in respect of mental health service delivery. During the past two decades, across governments and within mental health circles, much has been made about the success of governments' decisions to move away from custodial approaches to treatment and to de-institutionalize persons with chronic mental illness. In tandem with the implementation of this welcome policy shift has been the development and attempted implementation of successive National Mental Health Plans. Those involved have had honorable intentions however implementation of respective plans has steadily slowed down and at the same time, fallen short of the goals stated respective plans, so much so that the implementation of the third National Mental Health Plan has come to a virtual stop.

This falling short of the goals is a reflection of funding shortfalls, the position of the mental ill on the political radar screen and a lack of policy vision within state's and territory's mental health bureaucracies.

Indeed, right all across Australia, successive governments have seen the public mental health services and infrastructures as “cash cows” ripe for the picking. Governments’ decisions to move way from holding and treating the mentally ill within institutions thus provided the opportunity for each state treasury to plunder its state’s public mental health system. As each institution has been able to be closed, it has also been sold off with the respective government realizing of tens of millions of dollars. Instead of this money being directed to provide appropriate facilities and support services for the mentally ill, it has been re-directed away from the mental health system.

A most recent example of this is the action taken by the Government of Victoria a sell off to developers a large tract of land in Parkville for the construction of a Commonwealth Games village. The land in question was previously the sight of the Mont Park Mental Asylum and the sale is a clear example of cash being realized from the sale of land that was once on the assets list of the state’s mental health system. This cash has then been transferred into the Youth, Sport and Recreation Portfolio.

Governments have been able to get away with this sort of action because they have been able to exploit the generosity, good will and emotional state of families and carers who are close to persons suffering chronic mental illness. A consequence of this chain of events has been the emergence of new forms of incarceration, particularly for persons without family or carer support.

These new forms of incarceration can be seen in prisons, rooming houses, squats, city parks, in the spaces under highway bridges, around each city’s major bus and railway stations and in large city drains.

There is another pattern also emerging and this is the drift of young parents (who have a dual diagnosis - mental illness and drug dependency) with very small children, into small hamlet communities. At the present time in Victoria and elsewhere there is virtually nothing being done about this issue. Since mental health services are already inadequate in too many regional and rural areas, there are very high risks for these young family units should one or both of the parents experience a crisis.

The evolution of two mental health sectors.

A recurrent theme in the debate being held about the responsibility of governments with respect to health services, is the possibility that two levels of health care might evolve as a consequence of government policies about the structure and scope of Medicare. Those of us who are working in state/territory mental health systems might be judged to be a bit layback on the issue. **The fact is we know that in regard to the treatment of the mentally ill; two levels of care already exist.**

These two levels of health care for the mentally ill overlay the existing split between the public and private provision of services and they are noticeably different. They are characterized by the following:

- Two different modes of operation.

Public mental health services for in-patients now operate exclusively on a crisis- management basis. This fact is contributing to very high levels of staff burn out, low levels of job satisfaction and an inability of public mental health services to attract young nurses. These services are chronically under-funded and the experiences of many medical staff, who spend time in the public system while gaining training to become qualified psychiatrists, drives them into private practice as soon as they gain accreditation.

- Distinct differences in philosophy about what constitutes appropriate treatment for the person with acute mental illness.

There are noticeable differences between the private and parts of the public mental health systems with respect to attitudes to treatment. Money appears to be a major driver here although workforce culture and age profiles, differing financial controls and the evolution of new patterns of illness and new opportunities for treatment, all play their part.

We have reached a situation in this country where the public in-patient services are geared to short term, crisis management. These services are also restricted in the sense that the population of patients receives treatment is essentially made up of persons with psychotic disorders, with or without drug/alcohol dependency as well as persons who are considered to be at risk of suicide. For too many this access to specialist treatment and care is also transient and upon discharge, private GPs re-enter the process.

Issues like geographic location of residency ,lack of bulk billing, surgery hours, GP interest (or lack of) in mental illnesses, etc. then take their toll.

- Two distinct populations of patients.

As already described, the population of acute patients in the public mental health units is essentially made up of persons with psychotic disorders and persons who have been assessed to be at risk of suicide. This is in marked contrast to the private clinics where people with the full range of acute mental illnesses will be receiving specialist care and treatment.

These differences are clearly shown in Figure 1.

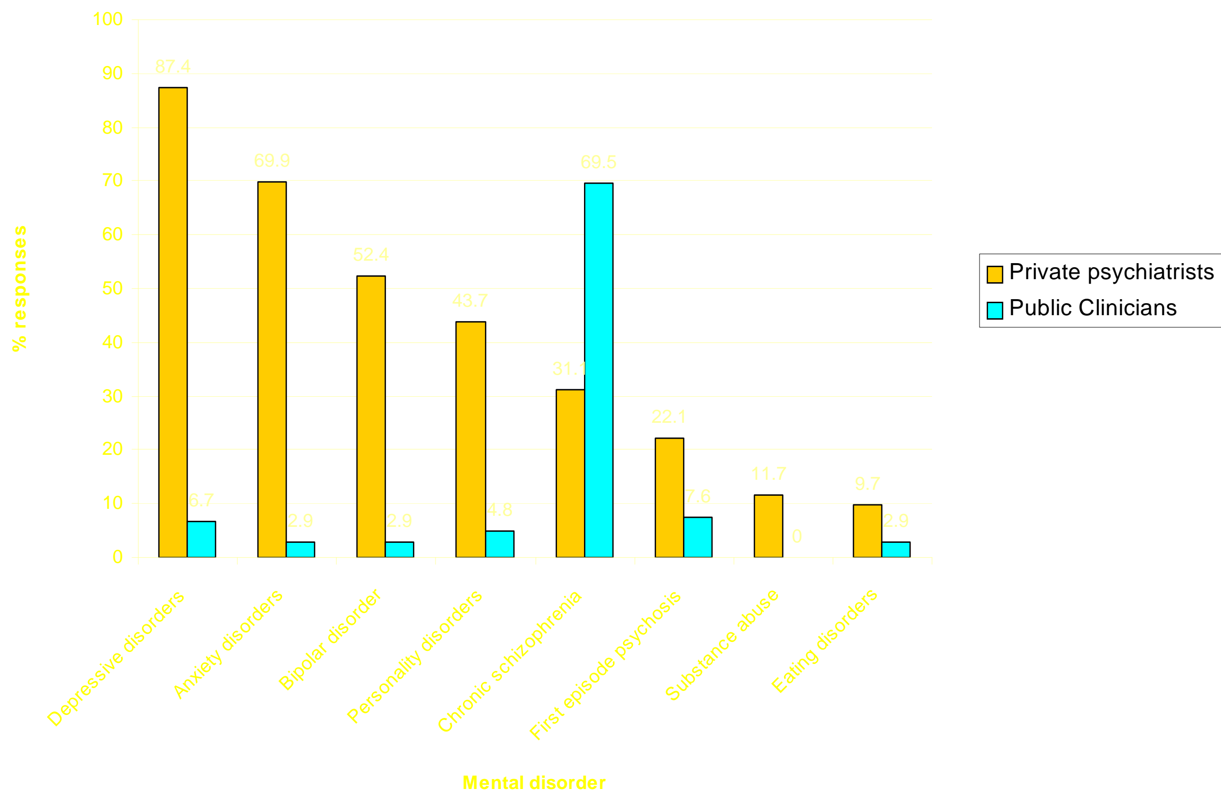

Figure 1. This shows the results of a questionnaire given to psychiatrists in private practice and clinicians (allied health staff and psychiatrists) in the Victorian mental health system. Each group was asked to indicate the proportions of patients with various mental illness that they were treating.

TERM OF REFERENCE C.

"Legislation may not change the heart, but it will restrain the heartless." ***MARTIN LUTHER KING.***

Mental health legislation needs to be re-visited.

In using the quote by Martin Luther King, I am not suggesting that the professionals and other staff who, every day treat, advise and care for the thousands of people with mental illness are indeed heartless. Some elements within the systems in which they are employed however are so.

There are significant deficiencies in the various Mental Health Acts across the country. In most states the last time that mental health legislation was reviewed to any significant degree, would have been at the time that governments decided to set out along the pathway to de-institutionalisation. Now, with access to modern drugs, the operation (in some situations), of new evidenced-based treatment regimes and the establishment of recognizable treatment patterns in community settings, it is time that mental health legislation was re-visited.

I believe that the best outcome for consumers and their carers, in respect of any review of mental health legislation, would be for the state, territory and commonwealth governments to embark upon a process that would lead to a set of principals first being developed and agreed at a ministerial level. A working party could then be appointed by the Council of Health Ministers to review all mental health legislation with a view to each government being able to introduce amendments or new legislation that would result in a lot of uniform provisions. The working party would be given 3-4 years to do this work.

If such a working party were to conduct a meaningful, Australia-wide public consultation, I believe that matters that could be covered by some modern uniform legislation would soon become evident. I want o draw the Senate Committee's attention to just one simple change. If this was provided in every Mental Halth Act, **the Cornelia Ray catastrophe might not have happened.**

Modern day treatment of schizophrenia can be very successful for many sufferers although not all. In the more difficult presentations, treatment resistance is a major problem and when the consumer takes him/herself off the medication(s). as

ith all other forms of illness, the doctor patient relationship is one on one and in addition, health professionals are now bound by privacy legislation. A downside of all of this is that **with a serious illness like schizophrenia the consumer has been almost completely disempowered.**

What is needed is a set of uniform procedures able to be accessed and exited by the consumer on a voluntary basis. Such a voluntary arrangement will mean that that the proposed legal provisions are not killed off on day by arguments about infringements of privacy law. The key to the legislation is that the person with schizophrenia could nominate a carer who would have some standing in his/her relationship with the consumer and with any health worker involved in the person's treatment. As a starting point to this sort of arrangement, members of **the Senate Select Committee could look at legal provision of an "advanced directive" in the Queensland Power of Attorney Act.**

Other legal provisions would enhance the empowerment of the consumer by requiring that for each patient, a treatment plan would be developed by the staff of the mental health service **in consultation with the consumer and the nominated carer.** Depending upon the type and course of any treatment, this plan might have to evolve beginning as an interim treatment plan and later becoming a "final" plan which would have legal standing. **In the first year following any acute episode, the treatment plan would be required to be reviewed (by a psychiatrist) at least twice, and at all other times, maybe annually.**

Any legislation of this sort should, as a bare minimum, prescribe certain elements relating to any treatment plan. These should cover:

- A statement of who is responsible for the preparation of a treatment plan (interim and final).

- An indication the breadth of matters that could be built into any plan (psychiatric, socio-economic, physical etc.).

- A requirement that the treatment plan is to be developed with input from the patient's carer.

- A requirement that a copy of any final treatment plan would have to be provided to the nominated carer. It would be re-issued after any review or amendment.

- Specify the maximum interval of time between the conduct of any assessment of the consumer by an authorised psychiatrist and the preparation of a final plan. It is acknowledged that any amendment may require the identification of an interim treatment plan and then a final plan.

- Indicate that one requirement in any review of a treatment plan would be to determine whether the treatment plan was actually working for the patient.

TERM OF REFRENCE D.

"When fortune fails, policy must prevail." ***Sir Robert Cecil, 1568.***

Early Intervention and Support Programs need to operate on a National Basis.

Currently there is a considerable amount of discussion amongst clinicians about the possible use of early intervention programs to treat and support young people with a dual diagnosis. **These people with dual diagnosis are no longer a sub-culture within the population of persons with mental illness, they are mainstream.** They are core business and need to be recognized for this by governments and by the providers of mental health services. No doubt the Committee will receive detailed documentation about this approach, the possible national impacts as well as the costs and long-term benefits.

I appeal to each committee member to come to a serious understanding about this modern-day pandemic and about what would be possible if an appropriate and proven early intervention program could be set up on a national basis. Senators will become informed that major gains can be made if these are put into place to deal with persons in the age range 14-25 with dual diagnosis. It will be informed that interventions that are directed at this age group will have a high impact as well as being very cost effective.

I want to extend this view and argue that the best outcomes will result if age-appropriate, intervention programs and support services are available to all persons in the first twenty years of life. What I am arguing is that any national program offering early intervention, treatment and support services should also encompass appropriate services for children who have experienced physical, psychological and sexual abuse, torture, refugee upheaval, parental loss, total family breakdown, extreme bullying and social discrimination.

I am saying that that the time has arrived for a nationally funded and co-ordinated early intervention program which:

- **Targets Australians up to age 20 years.**
- **Focuses upon their mental health and well-being.**
- **Offers a range of age-appropriate intervention programs.**

The extension of intervention and support programs so as to include the early childhood and juvenile years would create a situation where adverse childhood experiences, which are often the drivers for teenage risk taking, low self esteem, excessive drinking, drug experimentation and onset of anxiety and depression, are responded to appropriately in both the clinical and psychosocial sense. Coverage of the target population in this way, should offer over time, a strong possibility of reducing the numbers of teenagers and young adults feeding into the already-identified, co-morbid population.
The Australian community and its political leaders need to come to the realization and soon, that if now proven, early intervention programs are not funded and introduced on a national basis, we will see a significant portion of the next generation of adults written off.

The Private Mental Health System.

Mental health services are being provided to a significant degree within the private health sector. In the financial year 2002/2003, the private sector in Australia provided 43% of all hospital-based mental health services and 68% of same day mental health services.

Growth in the private sector has been substantial in recent years and has occurred in parallel with reductions in the size of the public sector beds. This increased growth in private mental health services has been accompanied by a shift in the

provision of care from being predominantly inpatient based to one of providing a significantly greater proportion of care on a same day basis and more recently via community outreach (hospital in the home type services). This is consistent with changes that have occurred in the public sector and demonstrates a commitment by the private sector to develop alternative models of care that extend the role of private mental health facilities.

Private Health Insurers.

There is an emerging issue that needs investigation here. It is the steady attempts by health insurers to restrict their coverage for services that are accessed private patients who have a chronic mental illness. This is being done by such things as the introduction of co-payments, failure to negotiate a new agreement with particular service providers and the introduction of new qualifying conditions for patients.

An issue here is that left unchecked, the new arrangements can become discriminatory. This is clearly a matter that can be and has to be sorted out at the Commonwealth level yet no party (either government, bureaucracy or statutory office) appears to be interested in sorting it out.

This discrimination against private patients with mental illness evidenced by:

- Introduction of co-payments for persons attending Day Program activities. The introduction of the co-payment has been done without any recognition of the patient’s prior membership of the fund and it has placed a large cost-burden upon the person with chronic illness.
- Inability of patients with mental illness to exercise their full right of portability
- Dispute between an individual service provider and an individual insurer can cause great distress to patients and in some cases the patient has been forced to find a new treating psychiatrist.

Impacts of this discrimination

Under the Health Act, the right of a health fund member to freely transfer membership between health funds is guaranteed by law. However during the past two years some insurers have been able to negotiate a rule change. ***I understand that this rule change only applies to patients requiring psychiatric or rehabilitation services/care.***

With the rule change in place, additional pre-conditions can then be set into place and this has the effect of qualifying portability provisions.

The amber light ought to be flashing for state governments here also. I predict that if contributors to private health insurance come to a view that, in respects of coverage for mental illness, the private insurers can sidestep some of their prudential obligations, then over time consumers will terminate their private health cover and this is going to put even more pressure upon the public mental health services. May be this is the real game plan of the insurance providers?

WORKFORCE ISSUES.

The Psychiatric Nursing Workforce – a looming crisis.

Mental health services across Australia (public and private) are engaged in a constant struggle to find suitably trained nursing staff. Everywhere hospital administrators speak constantly about this difficulty. It is my firm belief that unless there is a major policy shift complemented by co-ordinated actions by governments in respect of the education and training of psychiatric nurses, then in about ten or more years we will look back upon the present day as a halcyon period

Fact 1 - The average age of psychiatric nurses across Australia is around 48 years.

Fact 2- Many nurses working in the public mental health services are contributors to defined-benefit superannuation schemes.

Fact 3 – Nurses will be able to access their superannuation at age 55 or thereabouts

As these staff reach the critical age of 55 years, public mental health services will witness a "Calgary Stampede" of very experienced and highly trained professionals out of the services.

Strangely, no serious response to this looming crises appears to be being done at either the commonwealth or state levels. This is despite reports by consultants to state governments and a report to the Parliament of Australia on nursing requirements. If this inertia continues, then the big losers will be persons with serious and/or chronic mental illness.

If this inertia continues three other force that will come into play and each will amplify this looming crisis.

- The first is that in the absence of intervention programs that target this young population of persons with co-morbid illness, the group will continue to expand rapidly.

- The second is that at the end of this decade we will begin to see in Australia the beginning of a decline in the numbers of school leavers who will be available for tertiary education and training. Don't be alarmed! This is not some mysterious decline in average IQ in the population. Instead it reflects the drop off in the birth rate, which has been known about for at least twenty five years. In terms of ATTRACTIVE CAREER CHOICE, the health sector will have to compete a lot harder to maintain an educated and trained workforce.

- The third is the existing data for Australia indicating that over the next 25-30 years, the proportion of elderly persons with dementia disorders will increase by a factor of four. At some point during the progress of the dementia, many of these people will have associated mental illness.

The distribution of private psychiatrists.

Across all of the medical specialties, the psychiatrist stands out as a medical practitioner who is remunerated essentially for consultation time. The practice of psychiatry (with the exception of ECT administration) does not access to expensive infrastructure – medically equipped surgeries, medical imaging etc. Despite this, the practices of large numbers of private psychiatrists are concentrated in the capital cities. In Victoria and South Australia this situation is extreme.

Within a fifteen kilometer radius of the Melbourne GPO can be found the highest concentration of private, practicing psychiatrists in the southern hemisphere and the second highest concentration in the world, second only to Manhattan, USA. In South Australia there is not one resident private, practicing psychiatrist outside of the metropolitan area of Adelaide.

The evolution of these capital city concentrations of psychiatrists means that vast areas of Australia and thousands of people have virtually no access to psychiatry. This has to be seen as a demonstration of gross inequity given the fact medial undergraduate education and post-graduate psychiatric training are subsidized to such a high degree by all taxpayers.

The future supply of psychiatrist.

The workforce predictions with respect to adequately trained psychiatrists is almost as worrying as the situation previously described for nurses. At the end of 2004, the Royal Australian College of Psychiatrists estimated that there were about 150 psychiatric registrar positions vacant across the country. This has to be considered in conjunction with other survey data suggesting that up to 40% of the psychiatrists who are now in practicing privately, intend to move from full time to part time work by the end of the decade.

RESPONDING TO PATIENTS WITH A DUAL DIAGNOSIS.

The magnitude and the impacts of dual diagnosis patients (patients with concurrent mental illness and drug/alcohol dependency) within the public mental health systems are not understood by the public or by politicians at large. There needs to be a major education campaign about this health problem, so that in the mind of the person in the street, it is up there along with heart disease and breast cancer as a national health priority.

This must be accompanied by changes in service delivery with a rolling out of early intervention programs that I have already referred to. While the supply of allied health professionals is probably sufficient to respond to this, finding the psychiatric nurses is going to pose a major problem.

MEANINGFUL PRIVATE PUBLIC PARTNERSHIP ARRANGEMENTS.

The current mindset amongst many of the senior bureaucrats and administrators in the state's Mental Health Agencies is one that perpetuates the chasm that exists between the services being offered within the private and public areas. Because of this, significant opportunities for a possibly better patient outcome are missed with some regularity. The are a number of features that are not exploited by public mental health service providers and they include the following:

- While the public mental health units are operating at full capacity all of the time, there is often spare capacity in private clinics. As a way of relieving the pressure for beds, a contractual arrangement that would allow public patients to access the spare beds art a negotiated price should be possible. This idea appears to be anathema to government bureaucrats. In Victoria during the last state election period, an alternate solution was used by at least two of the Area Mental Health Services. Their solution was to pay for and place the less acute patients into local motels, a true "out of sight, out of mind" approach!

- While a number of the private clinics have Intensive Care Units, Queensland is the only state that allows a certified patient to be cared for in a private clinic. Surely this is an area of law that needs to be and can be changed?

- Allied mental health programs that are operated in the private clinics often have spare capacity. Again this could be accessed by the public mental; health service negotiating an arrangement with a private clinic.

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